Logic in Medicine

Fundamental ethical principles in health care

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The title of this paper seems to beg at least two questions.

(1) Is there sufficient common ground among the medical, nursing, paramedical, chaplaincy, and social work professions to justify looking for ethical principles common to "health care"?

(2) Do we really have sufficient logical grounds, or consensus among health workers and the public, to speak of "fundamental ethical principles in health care"?

Both questions will be examined in an attempt to clarify which requirements of morality are logically primary, or fundamental, to the ethics of health care. In colloquial usage the term "principle" is used very loosely to cover moral rules or demands that may be either logically fundamental or derived. Thus the seemingly repetitive phrase "fundamental principles" is used to clarify the distinction between the two.

I. Cultural and historical relativities in professional ethics

At first sight the ethical codes evolved in medicine, particularly in the Hippocratic tradition, and similar codes evolved more recently by nurses and the paramedical professions seem to be as much concerned with underpinning the identity and defending the interests of the relevant professional groups as with patients' or clients' rights.¹⁻⁸ If we focus attention on the attempts made in each to demarcate roles and responsibilities and to defend professional territory then it is difficult to see how it would be possible to arrive at any common principles of ethics of health care. We seem to be confronted with a series of independent "language games" of ethical discourse with constitutive principles and rules peculiar to each profession and the role responsibilities of each.

A functional or sociological analysis of the content of such codes would tend to emphasise the relativity of the "principles" invoked by each profession and would tend to explain the differences and common features among them in terms of the relative positions of the different professional groups in the power structure of the health services in any given society. Further, a historical analysis of the emergence of nursing, social work, and the paramedical professions would tend to highlight how, in the struggle to achieve an independent professional identity, these professions have had to contend with the dominant medical profession to negotiate and achieve a workable division of labour in each different system of health care.⁹

All this would tend to emphasise the relativity, historical contingency, and culturally specific character of any principles embodied in the different codes of health professionals.

The Hippocratic "tradition"

Similarly, an examination of the historical tradition of medical ethics, for example, would bring to light how confused and discontinuous it has been. Doctors like to boast of the continuity of the tradition of medical ethics stretching back over more than 2000 years to Hippocrates (about 420 BC). Closer examination, however, shows that the Hippocratic oath was peculiar to only one of several schools of medicine in antiquity. The Hippocratic tradition was virtually forgotten until reintroduced to Europe by the Arabs in the eleventh century. With the establishment of universities and schools of medicine in mediaeval Europe Roger II of Sicily in 1140 and Frederick II of Germany attempted to control medical practice, and at the time certain guilds of doctors adopted the Hippocratic oath as a basis for membership of the profession. At about the same time the church gave general endorsement to the oath, particularly because of its proscriptions of abortion and euthanasia.

The oath was never subscribed to universally, and after the Reformation and the fragmentation of Europe into nation states during the sixteenth and seventeenth centuries the Hippocratic tradition was more honoured in the breach than the observance. Only in the nineteenth century, with the development of modern scientific medicine and the struggle among doctors, surgeons, and apothecaries for professional dominance, did the oath re-emerge as the basis of the doctors' code of practice. It was a self conscious attempt at the time to invest medicine with a respectable image based in a scientific and ethical tradition going back to the Greeks.^{10 11} Although based ostensibly on the Hippocratic oath, the Declaration of Geneva (1948) of the newly formed World Medical Association speaks only of respect for human life from the time of conception and avoids commitment on the controversial issues of abortion, suicide, and euthanasia.¹² So much for the sacred tradition.

Between the fundamentalists of the (recent) Hippocratic tradition and the liberals, such as the authors of the Declaration of Geneva and others who have been willing further to dilute or relativise the requirements of the original oath, there have been tensions and disagreements as strong as those between fundamentalists and liberals in religion. Further complicating the picture is the explicit teaching on medical ethics by the Catholic church and orthodox Judaism. Protestant contributions to the debate have been various but without a specific body of principles being enunciated—and this is not to mention evolved and evolving traditions within Islamic, Chinese, and traditional medicine in other cultures.

The picture seems to be one of such moral and cultural diversity that it may seem to be inherently implausible to suggest that there might be underlying ethical principles common to health care as such.

II. Evidence of emerging consensus on principles

Several developments in the past 50 years have, however, pointed to the emergence of a consensus about values and principles in health care that cuts across sectional, national, and cultural differences and even suggests broad agreement about fundamental ethical principles.

World Medical Association

The evidence that emerged in the Nuremberg war crimes tribunal of appalling atrocities committed by Nazi doctors in the pursuit of so called scientific research and their abuse of clinical responsibility in their cooperation in torture and forced "experiments" in genetic research provoked not only public outrage but a restatement in several declarations of the World Medical Association of ethical principles common to doctors everywhere.¹² The Nuremberg Code (1947) restated the principle of informed and voluntary consent to treatment; the principle that experiments should be conducted only if they were "such as to yield fruitful results for the good of society" and if these results were unobtainable by other means; and, further, requirements that experiments should be conducted according to strict scientific methods and by competently qualified persons.

The Declaration of Geneva (1948) paraphrased the Hippocratic oath in rather bland general terms but emphasised the principles of confidentiality; non-discrimination on grounds of race, religion, political affiliation, or social standing; and respect for human life from the time of conception. Other later declarations elaborated on these principles in relation to several specific problems and practical applications, without perhaps adding any new principles.

The Declaration of Helsinki (1964) further elaborated the criteria for scientifically and ethically sound medical research with human subjects, attempting to clarify the distinction between therapeutic and non-therapeutic clinical research. The Declaration of Sydney (1968) attempted a statement on the definition of death (with reference to the recent developments of artificial life support systems and organ transplantation). The Declaration of Oslo (1970) attempted to square the demand for therapeutic abortion with the Hippocratic tradition, and the Declarations of Tokyo (1975) and Hawaii (1977) represented statements proscribing the participation of doctors (or members of the World Medical Association) in torture or other cruel or degrading treatment or punishment of prisoners; and, seeking to limit the abuse of psychiatric treatment, to enforce ideological conformity.

These statements of principle by the World Medical Association are put forward without historical or philosophical justification as self evident truths. The fact that they have been given wide endorsement by the profession world wide (in theory if not always in practice) suggests several possibilities—namely, that they might be self evident truths or simply bland truisms to which assent can easily be given; or that the values of Western medicine are sufficiently globally disseminated that the profession qua profession acknowledges a similar value base to its practice wherever modern medicine is practised; or that these statements of principle represent the emergence of a genuine moral consensus that transcends cultural, religious, and national differences.

Emergence of other health care professions

In nursing, social work, and the paramedical professions there has been a similar process of formulating codes of practice and statements of fundamental values and ethical principles. It is beyond the scope of this paper to discuss these in detail, but it is perhaps interesting to note these developments at national and international level. Further, the World Health Organisation has recently played an important part in helping this process in medicine and nursing and encouraging other professions allied to medicine to address ethical issues in practice.¹⁴ The International Council of Nurses formulated its *Code for Nurses* in 1953,² and

subsequently national nursing bodies followed suit—for example, the American Nurses' Association (1968)³ and the Royal College of Nursing (1979).⁴ Clinical psychologists were led by the American Psychological Association (1977),⁵ and other national bodies have followed with adaptations of their basic code. The British Association of Social Workers issued its *Code of Ethics for Social Workers* in 1975⁶ and *Confidentiality in Social Work* in 1977.⁷ The Central Council for Education and Training in Social Work also published *Values in Social Work* (1976).⁸ The other professions allied to medicine—physiotherapy, speech therapy, occupational therapy, chiropody, dietetics, and health education—have each begun developing similar codes, the Society of Health Education Officers having issued a discussion document on ethics in health education in 1986.

It may be argued that this fashion for codes of ethics simply mimics medicine, not only in terms of seeking professional credibility and respectability by "professing" a code of ethics but also in broadly following the principles that belong to the analysis of the caring relationship and its obligations within medicine and the Hippocratic tradition. If this is so the emerging consensus on principles in health care may be apparent rather than real and based anyway on imitation and adaptation of medical codes rather than original differences or novel insights.

Against this it can be pointed out that in both nursing and social work the codes in question require a much more explicit recognition of patients' or clients' rights—for example, the right to know, the right to privacy, and the right to adequate care. Social workers and psychologists have probably explored much more fully the nature and implications of confidentiality, health educators the right to information and self help, and nurses in particular the health workers' role as an advocate of the rights of the vulnerable individual and the responsibility to work to restore autonomy to the patient who has lost it by virtue of injury, disease, or mental disorder.

Regulating biomedical research—the American experience

Public concern and media publicity about the use of prisoners as research subjects resulted in the setting up by the United States government of a National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research. Faced with the apparent cultural diversity and relativity of principles professed in health care and the biomedical sciences, the commission had to formulate guidelines for the Department of Health, Education, and Welfare.

The Belmont report, which represents the collected research of the commission over several years, states an interesting consensus view that emerged over fundamental principles among members of the multiprofessional and interdisciplinary commission¹³ (it represented a wide variety of health workers, lawyers, philosophers, theologians, and social scientists). They enunciated the principles of beneficence, justice, and respect for persons as fundamental to the ethics of health care and argued the case in convincing detail in several reports that other ethical principles could either be derived from or reduced to these.

III. Historical, cultural, and logical grounds for fundamental principles

Now the fact that one commission (and an American one at that) has argued that beneficence, justice, and respect for persons are basic or fundamental ethical principles does not prove anything in itself (leaving aside the volumes of research papers supporting the Belmont report). Such a consensus might reflect only a consensus among members of the commission or among Americans and not have universal application. If this view is defensible it must, firstly, be compatible with the historical evidence; secondly, make sense of

cultural diversity and evident moral relativities; and, finally, be logically coherent.

In the remainder of this paper I shall consider each of these issues in turn and finally conclude with a brief discussion of some of the practical implications of the three basic principles.

Historical arguments—the Hippocratic tradition

When considering the historical evidence it may be instructive to begin with the Hippocratic oath itself.¹⁴ There are various versions of the oath, but the following may be taken as representative:

I swear by Apollo the physician, by Aesculapius, Hygeia and Panacea, and I take to witness all the gods, all the goddesses, to keep according to my ability and my judgment the following Oath:

To consider dear to me as my parents him who taught me this art; to live in common with him and if necessary to share my goods with him; to look upon his children as my own brothers, to teach them this art if they so desire without fee or written promise; to impart to my sons and the sons of the master who taught me and the disciples who have enrolled themselves and have agreed to the rules of the profession, but to these alone, the precepts and the instruction. I will prescribe regimen for the good of my patients according to my ability and my judgment and never do harm to anyone. To please no one will I prescribe a deadly drug, nor give advice which may cause his death. Nor will I give a woman a pessary to procure abortion. But I will preserve the purity of my life and my art. I will not cut for stone, even for patients in whom the disease is manifest; I will leave this operation to be performed by practitioners (specialists in this art). In every house where I come I will enter only for the good of my patients, keeping myself far from all intentional ill-doing and all seduction, and especially from the pleasures of love with women or with men, be they free or slaves. All that may come to my knowledge in the exercise of my profession or outside of my profession or in daily commerce with men, which ought not to be spread abroad, I will keep secret and will never reveal. If I keep this oath faithfully, may I enjoy my life and practise my art, respected by all men and in all times; but if I swerve from it or violate it, may the reverse be my lot.

Firstly, it is interesting to note how the doctor hedges his bets by swearing in the names of the god of the physicians (Apollo), the god of the surgeons (Aesculapius), and the goddesses of prevention (Hygeia) and cure all (Panacea). The next part of the oath represents a classic statement of the case for a closed shop, based on medical protectionism and a monopoly in the control of medical knowledge and practical skills.

We see here at the very beginning a tension in medicine between the exoteric character of medicine as a self styled scientific discipline and the esoteric character of the profession as a semisecret masonic brotherhood based on charisma and magic. It is important to remember that the Hippocratic school was closed to all but those prepared to undergo the prescribed religious rituals and rites of initiation. Only then could access be gained to medical knowledge and training in the secret skills of the physician or surgeon. The amusement of modern medical students at the idea that their respect for their teachers should extend to a commitment to give them and their offspring financial support and free medical training springs from an awareness of this peculiar tension: on the one hand the secret, cultic, magic side of medicine as an art (the charisma or placebo effect of the drug "doctor" still being the most potent instrument in the doctor's armamentarium¹⁵); and, on the other, the open, scientific, experimental side of medicine as a science (based on replicable experiments, controlled trials, and openly published and testable results).

The most specifically ethical prescriptions of the oath may readily be grouped under the three principles of beneficence, justice, and respect for persons.

The duty to do good and avoid doing harm (beneficence or non-maleficence)

"I will prescribe regimen for the good of my patients according to my ability and judgment and never do harm to anyone."

"In every house where I come I will enter only for the good of my patients, keeping myself far from all intentional ill-doing. . . ."

Fairness to all or non-discrimination (justice)

The references are to the non-exploitation of the vulnerable, particularly women, children, and slaves (including any kind of sexual abuse). Further, the commitment not to pretend to skills the doctor lacks: "I will not cut for stone . . . but leave this operation to be performed by practitioners (specialists in this art)."

Respect for life and the dignity of patients (respect for persons)

"To please no one will I prescribe a deadly drug, nor give advice which may cause his death. Nor will I give a woman a pessary to procure abortion." (These are interpreted widely as proscriptions against euthanasia, assisted suicide, and abortion.)

"All that may come to my knowledge in the exercise of my profession . . . which ought not to be spread abroad, I will keep secret and never reveal." (This is recognition of the patient's right to privacy and the doctor's duty to maintain confidentiality.)

A detailed analysis of the extant declarations of the World Medical Association will show that the various principles enunciated can be derived from the three principles of beneficence, justice, and respect for persons or represent concrete applications of them. For example, the principle that subjects of biomedical research or recipients of medical treatment should give informed and voluntary consent is a corollary of the principle of respect for persons; the principle of non-discrimination on grounds of race, religion, and so on a corollary of the principle of justice; and the requirement that the doctor should accept full responsibility for treatments prescribed for incompetent patients or for any research subjects is a requirement of the principle of beneficence.

Gillon, in his otherwise excellent series on philosophical medical ethics, takes for granted the primacy of the three basic principles without showing whence they originate, how they are interrelated, or how other issues he discusses are related to these principles.¹⁶⁻²³ He seems to assume that it is intuitively self evident that these principles are fundamental to medical ethics. The interdependence of the principle of beneficence and non-maleficence ("primum non nocere") can be shown to be positive and negative formulations of the same principle. The requirement of truth telling or honesty is likewise derived from the principle of honour or respect for the patient as a person with a right to know. It is tempting, particularly within the fairly intact and conformist values of British medicine, to take for granted as self evident truths the principles on which our tradition is based and to use a kind of circular intuitionist argument to justify these principles as fundamental. Other kinds of demonstration are needed to justify the claim that beneficence, justice, and respect for persons are basic principles.

Cultural analysis—the evolution of principles

Cultural analysis can be offered to show the evolution of these three principles in ethical systems of widely different kinds. There was a time, earlier in this century, when arguments to the effect that all ethical principles are relative and culturally specific were useful to challenge the cultural and moral imperialism of the West. Today not only is it more urgent to find common principles on which to found peace and disarmament and to ensure human survival on this planet but also the creation of international agencies. The formulation of, for example, the UN Declaration of Human Rights, the development of international law, and a revival of interest in the concepts of natural law bear testimony to a growing global consensus about fundamental human values and common ethical principles. Even moral philosophers (who perhaps have a vested interest in keeping a free market economy in moral systems going) are beginning to reflect a growing recognition that beneficence, justice, and respect for persons are in a sense basic to what ethics in general, and the ethics of health care in particular, is about.^{24 25}

GENERAL ANTHROPOLOGY

This is perhaps not surprising if we reflect both on the evolution of human beings within the structure of the family and tribal societies and on the broader history of our own Western culture. In all human societies people are born, grow to maturity, reproduce, become old, and die. These common features of human experience alone suggest that there are likely to be commonalities in the way that we perceive values or the conditions that make possible human flourishing. In family life and tribal society the quasiparental duty to care—for children, the weak, and the vulnerable—is taken for granted as being basic to social organisation and necessary for survival of the species. As children grow to maturity and seek recognition of their rights and a place for themselves in society so the demands of public justice (for liberty, equality, fraternity) begin to emerge. As people acquire more power and share in their society and are able to exercise more independent responsibility, and particularly as roles are reversed and the older generation become more dependent, the issue of respect for individual dignity and autonomy of people as people becomes an important issue in society.

CONTRIBUTIONS OF SPECIFIC CULTURES

In family and tribal life, religious orders, and hierarchical and monarchical societies the offer of a protective beneficence by the ruler of the community requires a matching duty of cooperative obedience in those subject to his or her rule. Here beneficence is the pre-eminent organising principle of society, taking precedence over justice and personal rights. With the development of urban civilisation, like the city states and commercial empires of the Greeks and Romans, traditions of public and international law began to evolve, based on the concepts of a rational moral order in Greek philosophy and universal natural justice in Roman law. Though Jewish and early Christian societies incorporated strong elements of beneficent paternalism and concern with social justice, their unique contribution has been to emphasise the demands of an ethic of love—namely, respect for the unique dignity and rights of the individual person. In each of these types of social organisation, where, respectively, beneficence, justice, and respect for persons are the primary organising principles, elements of the other principles can be found.

This is not surprising, for in general social organisation is complex and the moral order must have corresponding complexity or ability to accommodate other principles. Thus in traditional tribal or family life, or in the traditional professions (law, medicine, and the church), the values of beneficent paternalism are paramount but do not necessarily exclude concern with justice for all or respect for certain individual rights. In socialist societies concern with social justice has been paramount, but this does not prevent the socialist state from exercising a kind of paternalistic authority in the name of protective beneficence. While in practice such systems may restrict individual rights and liberties, apologists for socialism would say that without universal social justice individual rights become a luxury enjoyed by the few. Liberal and democratic systems purport to make respect for personal rights and liberty the supreme organising principle of society. But without the built in safeguards of universal justice, or the willingness of the state to act to protect the vulnerable, individuals have no protection against discrimination, injustice, or exploitation by the stronger.

DIFFERENT KINDS OF CARER-CLIENT RELATIONSHIPS

In medicine and the caring professions ethical codes historically have been developed by the professions in response to demands (from the consumer side) that professionals justify the faith clients place in their competence and integrity; but these are also required (from the supply side) to legitimate professional intervention in a crisis. The paradigm for code based ethics is crisis intervention—where the patient is unconscious, incompetent, or extremely

vulnerable and the doctor, for example, is required to take action and accept full responsibility for the treatment given. In such a setting the doctor can only fall back on his own personal ethical code or that of his profession. Not surprisingly in code based ethics protective beneficence, or the duty to care, has paramount importance.

In the consulting professions, where a client voluntarily seeks help with a problem, but is fairly independent, mobile, competent, and continent, and the professional carer is in the position of offering a service, being paid to care, the two parties can be said to enter into a contractual relationship. This contract may be formally negotiated or may be informal and implicit. The crucial difference is that contractual ethics, as distinct from code based ethics, relates to a setting where the contracting parties recognise mutual and reciprocal rights. Contractual ethics are governed by considerations of justice (including civil and criminal law where necessary).

In situations or chronic or terminal care another kind of model may be required. Because the nature of the therapeutic relationship or pattern of care changes, as do the practical and moral considerations governing both, the "contract" may need to be renegotiated. For example, when a patient is dying, or his condition is chronic, and the doctor has exhausted his repertoire of therapeutic measures, then, assuming that the patient is competent and consultable, to continue to offer care (under the guise of "treatment") would be officious and misleading unless the patient is consulted about the proposed course of palliative care and given the opportunity to accept or reject it. The continuation of the caring relationship under these circumstances requires a different kind of commitment on both sides—what May has called a "covenantal relationship"—because, like a biblical covenant, it requires a commitment of mutual fidelity between the carer and the one cared for. The carer accepts the role of patient advocate and takes on supererogatory duties in return for the love and trust of the patient. In covenantal ethics respect for personal rights takes precedence over considerations of justice or mere beneficence.²⁶

Philosophical arguments for the logical priority of certain principles

A philosophical analysis of ethical systems can provide another kind of argument for recognising the existence of certain fundamental ethical principles in health care. The argument is a logical one, based on the formal requirements for a coherent ethical system as such. This type of argument, developed by Immanuel Kant (1724-1804), is descriptive and formal and is not really persuasive or prescriptive unless taken together with the types of arguments already advanced.

In his *Groundwork to the Metaphysics of Morals* (1785) Kant argued that the concept of person or personhood is a primitive concept in ethics.²⁷ Without it ethics cannot get started, for the concept of person—that is, an individual who is a bearer of rights and responsibilities—is both formally constitutive of ethics and practically definitive of the membership and scope of the moral community.

The concept of person or even a derived list of personal rights, however, would not alone be enough to found a coherent system of ethics. Personal rights or statements of the necessary and sufficient conditions for persons to be persons would not provide an adequate basis for a system of social ethics unless these rights could be justified as rights for all. This requires a principle of universalisability, as Kant called it, which is really a requirement of justice or universal fairness.

Even the concept of persons as bearers of rights and the concept of universal justice, however, would not be sufficient to ensure a workable system of social ethics without a further principle, which might be called the principle of reciprocity—that is, the recognition of a duty to care for others as you would have them care for you. In the real world we are not all equal. At certain times in our lives we are all very vulnerable and unable to claim or defend our rights—as infants, when sick, injured, or mentally disordered, or when senile or dying. Unless we build in a principle of reciprocity we have no way of grounding the obligation to care for the vulnerable.

Hence the principles of respect for persons, universal justice, and beneficence mutually imply one another as formal and practical requirements for any coherent system of social ethics.

The purpose of this paper has been to argue the case for recognising certain principles as being fundamental to ethics in general and to medical ethics or the ethics of health care in particular. It is not the purpose of this paper to discuss all their possible practical applications, but a few might be mentioned.

IV. Respect for persons, justice, and beneficence

Respect for persons means basically treating patients as persons—that is, individuals with rights. It means respecting the autonomy of subjects and protecting those who may suffer loss of autonomy through illness, injury, or mental disorder and working to restore autonomy to those who have lost it. It means recognising the fundamental rights of patients as persons—namely, the right to know, the right to privacy, and the right to treatment. Clearly there is a tension among these rights, as in attempting to ensure informed and voluntary consent, in setting sensible limits to confidentiality or physical privacy, or in distinguishing between care and treatment or choices of treatments. Respect for persons means exercising care in such a way as to maintain the optimum level of the patient's autonomy by sharing knowledge and skills as well as treatment with the patient to avoid creating and perpetuating relationships of dependency.

Justice, or the demand for universal fairness, stands in a tense relation with respect for persons. The exercise of individual rights may have to be limited or circumscribed in the interests of the common good—for example, freedom of movement and individual privacy may have to be compromised by public health measures to contain epidemics. We are not concerned here with retributive justice but with distributive justice. There are, however, some analogies with retributive justice in the social controls imposed on the mentally disordered and loss of rights of patients in institutional care, as the sociological analysis of sickness behaviour as a form of deviance shows.^{28 29}

Justice in health care, however, is more broadly concerned with equalising as far as possible the distribution of health care resources and opportunities for care and treatment, tax burdens and responsibilities, and risks and benefits to ensure fairness to individuals and groups. Justice to individuals means primarily non-discrimination on the basis of sex, religion, social standing, political affiliation, youth, old age, handicap, or mental disorder, and equal opportunity in terms of access to resources, including preventive and treatment health services and the benefits of research. Justice in terms of equality of outcome for groups (see, for example, the Black report³⁰ relates to the "political" responsibilities and accountability of health workers in controlling and allocating resources and in planning, research, and development. It may also entail accepting responsibility for practising positive discrimination and campaigning for resources as well as maintaining services and defending standards of care and treatment.

Beneficence has tended to enjoy a bad press recently, with much emphasis being given by pressure groups to patients' rights or by politicians to debates about justice and the political economy of health services. Nevertheless, beneficence is an indispensable value in health care, as it is in ethics generally. The duty to care is not only about recognising a reciprocal responsibility for one another but also in particular about recognising a duty to protect the vulnerable—that is, accepting the role of advocate of the rights of those who are unable to defend their own rights. It relates too to the responsibility of health workers to share their knowledge and skill

(for "knowledge is power")—that is, to use it to enhance the autonomy, skills, and ability of people to take responsibility for their own lives and their own health, to help themselves to health. This means maximising the educational potential of every clinical encounter and all health workers recognising their need to develop and enhance their education and communication skills.

Conclusion

There are good grounds for us to recognise respect for persons, justice, and beneficence as fundamental principles in ethics—principles with particular meanings and implications when applied to the analysis of relationships between carers and clients in health care (or for that matter to the wider responsibilities of health workers in teaching, research, and planning as well as in the administration of health services). It has not been the purpose of this paper to discuss these practical applications or implications in detail but to set out some of the arguments for the primacy of these principles.

Neither has it been considered appropriate to discuss those second order theories we adduce to justify these principles or any particular rank ordering of them (such as utilitarian, deontological, natural law, or agapistic theories). The basic contention is that respect for persons, justice, and beneficence are fundamental principles in a formal sense. How we view these principles in practice will depend on our particular culture and experience and the kinds of metaethical criteria we use for interpreting, applying, and justifying these principles and others we may derive from them.³¹

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